



## Mandatory Training Workbook 2015

### Health and Safety & Risk Management

#### Clinical Staff

My



### Checklist

- *Read through this section of the workbook.*
- *Complete the on-line assessment on [My PACT](#)*
- *If further information is required please contact the Risk Manager on 1051*

## Learning Outcomes – mapped against Core Skills Framework

- Describe where additional information about health and safety, including relevant national legislation or guidance and local policies, may be found
- Recognise work place hazards and/or incidents and the need for preventative and appropriate remedial action. Understand and promote safe working practices
- Demonstrate the importance of acting in ways that are consistent with legislation, policies and procedures for maintaining own and others' health and safety.
- Demonstrate how to report any issues at work that may put health and safety at risk.
- Identify and assess the potential risks involved in work activities and processes for self and others
- Identify individual responsibilities in reporting incidents and describe details of the policies and processes in place for reporting such incidents
- Demonstrate an understanding of the need to co-operate with their employer on health & safety matters and correctly use work items provided by their employer. For example, this may include the use of personal protective equipment in accordance with the appropriate training and/or instructions.
- Demonstrate an understanding that individuals must not misuse anything provided for their and others' health, safety or welfare.

In order to be able to take care of ourselves and others at work, we need to identify what the possible causes of us being harmed are (the hazards), what the consequences and potential harm is likely to be (the risk), and then do something about it (the control measure).

**Although the Trust has several experts and advisers who can advise and support you, Risk Management is the responsibility of everyone in the Organisation.**



Key areas of Risk Management in which staff must be involved are:

- Identifying hazards and risks by risk assessment of service delivery and individual patients.
- Significant event reporting and investigation (includes incidents, accidents health and safety, non clinical and unexpected events).
- Complaints handling

Risk management should be embedded in everything that we do, key risk areas for this trust are as follows;-

- Patient safety – including medication errors, slips trips and falls, wrong site surgery etc
- Health and safety
- Infection prevention – patient and staff
- Manual Handling / ergonomics
- COSHH – (control of substances hazardous to health)
- Radiation protection
- Financial and corporate risks

Top reported patient safety incident categories are:

Equipment  
Medication  
Falls  
Documentation  
Delay in obtaining assistance  
Communication Error or omission  
Pressure sore  
Treatment error  
Discharge delay  
Moving /handling

### ***Significant event reporting***

The Trust is reporting serious incidents to external agencies based on the information completed by staff on the incident forms. The two key agencies are:

- National Reporting and Learning Service (NRLS) for all patient-related events.
- Security Management Service (SMS) for all physical assaults on staff. The SMS is notified of events via the significant event form (in this case the form is not anonymous).

### ***Human errors, root causes and systems design***

We have all heard the old adage that 'everyone makes mistakes' the reality is that this is true, if we concentrate on the errors made and do not examine the root causes of adverse events, incidents will continue to occur. To prevent

incidents occurring we must put systems in place to prevent errors in resulting in harm to patients. Examples of systems include different connectors to ensure that the wrong drug cannot be connected, separate storage areas for drugs, policies and procedures, checklists, and bar coded access to blood, but there are many more.

Emerging Patient Safety Issues:

- Patient falls may lead to serious harm occurring
- Patient / site misidentification may lead to wrong surgery / wrong site surgery being performed
- Unsafe Ward environments may increase the risk of suicide, self harm, violence aggression, and sexual and racial harassment and abuse.
- Poor prescribing and dispensing of drugs may lead to deaths through accidental overdose.

### ***Patient Safety***

Patient safety is not just for doctors, nurses, and other clinical staff. Patient safety is affected by systems and processes as well as specific clinical care:

- An incorrectly typed or addressed referral letter may mean delay in diagnosis or treatment.
- A poorly handled telephone call may result in a patient not seeking help when they need it.
- A box, trolley or piece of equipment left unattended in an inappropriate place could result in someone falling over it.

### ***Barriers to reporting***

People can be reluctant to report events for several reasons:

- Fear of reprisals, lack of trust
- Additional burden of work – too busy
- Fear of exposure of weakness, lack of competence, suspension, litigation
- Loss of reputation, income or job
- Lack of action to stop things happening again

The Trust Policy is to promote a fair blame culture and that only under specific circumstances would disciplinary action be considered following a reported event. The trust utilises the NPSA incident decision tree to support these decisions.

### **Reporting Concerns – Speak out safely**

All staff, both clinical and non-clinical, have a duty to report their concerns using whichever process or procedure they feel comfortable with. Concerns must be reported by:

- Reporting as an incident
- Following Raising Concerns at work policy.
- Clinical supervision.
- Team meetings.
- Management Supervision.
- Emailing or telephoning the Risk Management Department.

All staff are encouraged and supported to report concerns

### **Risk Assessment**

All departments are required to carry out risk assessments of their environment and of procedures completed within their area. These include general risk assessments of a hazard noted, patient specific assessments (such as falls, manual handling etc) and specific hazard assessment (such as manual handling and COSHH).

#### **5 steps to carrying out a Risk Assessment**

**Step 1:** Identify the hazards

**Step 2:** Decide who might be harmed and how

**Step 3:** Evaluate the risks and decide on precautions

**Step 4:** Record your findings and implement them

**Step 5:** Review your assessment and update if necessary

The trust has a standard template for risk assessment. **Completed risk assessments should be kept in the area they have been developed in.** These will then be used to make up the directorate risk registers.



### **Security Management Service (SMS)**

The Trust is required to report all physical assaults on staff whether or not an injury occurs or if the police are called.

The **Trust** has trained a local security management specialist to investigate violent events and make sure that the Trust supports staff involved and prosecutes the offender where appropriate. The **Security Manager** offers conflict Resolution training to staff, to try and reduce the number of physical assaults. The SMS are notified of events via the significant event form. They also have a legal department to assist staff or the Trust on prosecuting offenders if appropriate. Contact details can be provided for the SMS by contracting the Risk Management Department.

# Introduction to Venous Thromboembolism

## Rationale for Policy

- Political
- Clinical
- Economic

## A Government Issue

Following the publication of the House of Commons Health Select Committee 2005 *Report on the Prevention of Venous Thromboembolism in Hospitalised Patients*, The All-Party Parliamentary Thrombosis Group (APPTG) was formed raise awareness among parliamentarians about risk and management of VTE. The National VTE Prevention Programme was established and the NICE guidelines for surgical patients produced.

## Epidemiology

VTE accounts for 25000 deaths in England. This is more than the total number of deaths due to AIDS, breast cancer and RTAs combined, and greater than 25 times the number of deaths due to MRSA.

DVT affects 20% of major surgery patients, including 40% of major orthopaedic surgery patients. 5% of high risk patients have fatal PEs, but less than 1 in 10 fatal PEs is diagnosed before death. The risk of death from hospital-acquired PE is over a thousand-fold greater than the much more publicised air travel. Indeed, VTE accounts for 10% of in-hospital deaths.

The full Impact of post-thrombotic syndrome is still not well known.

## Financial burden

The total cost to the NHS for managing Deep Vein Thrombosis is estimated at £640 million. Accordingly, there are hospital reimbursements are driven by Commission for Quality and Innovation (CQUIN) targets:

- VTE risk assessment completed and staff aware of protocol: 90%
- Completion of further risk assessment at 24hours
- Appropriate prophylaxis prescribed: 90%
- Written/verbal information given to patient: 90%.

## PATHOGENESIS

As with the genesis of any intravascular clot, VTE is the product of factors comprising Virchow's triad:

- Hypercoagulability
- Haemodynamic disturbance (stasis, turbulence)
- Endothelial injury.

## Patient-related Risk Factors for Thromboembolism

There are numerous risk factors for VTE development, including:

- Age - there is an exponential increase in risk of age which largely reflects greater immobility and coagulation activation.
- Obesity - there is a 3 times increased risk in patients with a body mass index of greater than 30kg/m<sup>2</sup>.
- Previous VTE - there is an increase recurrence rate of 5% per year.
- Immobility (e.g. paralysis, limb in plaster) - bed rest for longer than 3 days increases the risk by factor of 10.
- Hospitalisation due to acute illness - increases risk by a factor of 10.
- Thrombophilia - such as high coagulation factors, antiphosphid lipid syndrome, high homocystine, low coagulation inhibitors (antithrombic, protein C or S) activated protein C resistance (eg factor 5 Leiden).
- Active cancer or cancer treatment – 7 times risk.
- Active cardiac or respiratory failure
- Acute medical illness
- Behcet's disease
- Central venous catheter in situ
- Continuous travel of more than 3 hours approximately 4 weeks before and after surgery
- Irritable bowel disease (e.g. Crohn's disease or ulcerative colitis)
- Myeloproliferative diseases
- Nephrotic syndrome
- Paraproteinaemia
- Paroxysmal nocturnal haemoglobinuria
- Pregnancy or puerperium
- Recent myocardial infarction or stroke
- Severe infection
- Use of oral contraceptives or hormonal replacement therapy
- Varicose veins with accompanied phlebitis

### **Procedure-related Risk Factors for Venous Thromboembolism**

Any major operative procedure poses a risk for developing venous thromboembolism, but in particular:

- Major orthopaedic, especially hip replacement
- Major gynaecological
- Abdominal

The longer the procedure, the greater the risk of developing venous thromboembolism, related mainly to the associated immobilisation, with at-risk durations being greater than 30 minutes.

Regional anaesthesia reduces DVT risk by 38%, PE risk by 43% and proximal DVT risk by 70%, compared with general anaesthesia. Because of the risk of spinal haematoma, the timing of insertion and removal of epidural/spinal catheters in the presence of pharmacological prophylaxis.

### **DIAGNOSIS OF PRIMARY OUTCOMES**

Clinical diagnosis alone is unreliable, and investigative confirmation is required.

### *DVT*

- Radionuclide (125I)fibrinogen uptake
- Venography
- Doppler ultrasound
- Magnetic resonance imaging (MRI)

### *PE*

- Pulmonary angiogram
- Ventilation/Perfusion scan (pulmonary scintigraphy)
- CT pulmonary angiogram (CTPA) – currently the standard investigation
- Autopsy

On electrocardiography, the classical S1 Q3 T3 actually has low sensitivity (20%) and specificity.

### *Major Bleeding*

Results in death

Decrease in haemoglobin by 2 g.dl<sup>-1</sup> or more

Transfusion of at least 2 units of blood

Retroperitoneal, intracranial or intraocular

Resulting in a serious or life-threatening clinical event

Requires surgical or medical intervention.

## **VTE PROPHYLAXIS**

### **Mechanical Prophylaxis**

- Graduated compression stockings (GCS)
- Intermittent pneumatic compression (IPC)
- Foot impulse device (FID, foot pump)
- Electrical stimulation

Mechanical methods individually reduce DVT incidence by similar magnitudes (relative risk of DVT 0.49, 95%CI 0.43-0.57). Combining mechanical methods has no significant beneficial effect. However, mechanical methods as an adjuvant to pharmacological prophylaxis reduces the risk of DVT by 50% (RR 0.50, 95% CI 0.35-0.72) and the risk of PE by 60% (RR 0.40, 95% CI 0.25-0.62) but although there is no significant impact on proximal DVT.

Contraindications to GCS include

- Massive leg oedema
- Pulmonary oedema
- Severe peripheral arterial disease
- Severe peripheral neuropathy
- Major leg deformity
- Dermatitis or any other superficial skin condition

### **Pharmacological Prophylaxis**

- Heparins
  - UFH (5000-40000 Da)
  - LMWH (3000 Da)
- Danaparoid

- Warfarin
- Aspirin
- Fondaparinux
- Factor Xa inhibitors

UFH and LMWH reduce risk of DVT and PE but increase risk of major bleeding.

Any heparin is more effective than aspirin or oral anticoagulants in preventing DVT. There is no preferential dose for LMWH and the timing of its commencement relative to operation is inconclusive. While extension of use of LMWH beyond discharge reduces post-discharge DVT, this presents logistical problems.

Aspirin is associated with a 24% reduction of DVT and 39% reduction of proximal DVT, without significant risk of major bleeding. As an adjuvant to heparin there is no significant thromboprophylactic benefit but there is a 47% increased risk of major bleeding. Compared to heparin, it is an inferior DVT prophylactic, and is inferior to mechanical prophylaxis for DVT.

Fondaparinux is a synthetic pentasaccharide, based on antithrombin binding site of heparin, acting as catalyst to antithrombin inhibition of coagulation factor Xa. It is the single most effective thromboprophylactic agent, reducing DVT risk by 48% compared to LMWH. However, because of its significantly greater bleeding risk (RR 1.49, 95% CI 1.16-1.92 compared with LMWH), it is *not licensed for use in cardiac or thoracic surgical patients*. Post-discharge use reduces risk of DVT by 96% and of PE by 89%.

### **Vena caval filters**

Vena caval filters are recommended for patients with recent (<1 month) or current DVT in whom anticoagulation is contraindicated. In a randomised controlled clinical trial of 400 at-risk hospitalised patients, there were more PEs in the no-filter group, and more symptomatic PEs in no-filter group at 2 years, with the difference remaining statistically significant at 8 years. There were significantly more recurrent DVTs in filter group. There was no difference in major bleeding.

### **Patients' perspective**

4% of LMWH patients complained of side effects compared with 26% of patients with external mechanical compression complaining of discomfort, inconvenience, problems and/or side effects (most commonly perspiration).

### **General Measures**

- Early mobilisation / leg exercises
- Leg elevation.
- Continuous passive movement.
- Oral hydration.
- Patient information.

## **NATIONAL STANDARDS**

National standards have been set to produce a quality benchmark for health institutions.

### *NICE Quality Standards*

1. All patients, on admission, receive an assessment of VTE and bleeding risk.
2. Patients are re-assessed within 24 hours of admission for risk of VTE and bleeding.
3. Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance.
4. Patients/carers are offered verbal and written information on VTE prevention at the time of admission.
5. Patients/carers are offered verbal and written information on VTE prevention as part of the discharge process.
6. Patients provided with anti-embolic stockings have them fitted and monitored in accordance with NICE guidance.
7. Patients receive extended postoperative VTE prophylaxis in accordance with NICE guidance.

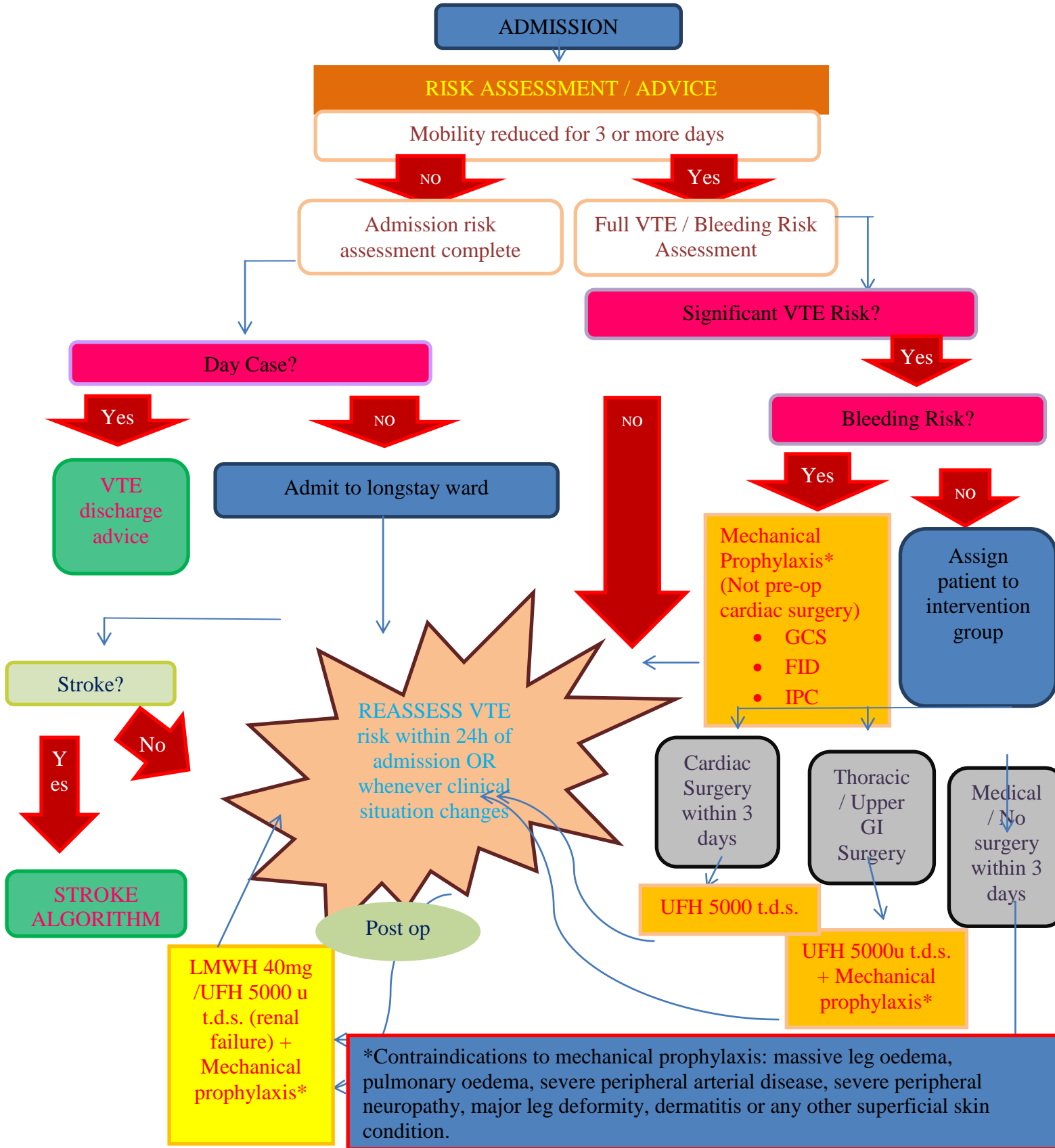
### *NHSLA Standards*

1. Process/risk assessment for identifying patients at risk of a venous thromboembolism
2. Prophylactic treatment regime for high risk patients
3. Procedure to be followed if venous thromboembolism is suspected
4. Management of the patient once a positive diagnosis has been made
5. Organisations expectations in relation to staff training

To help achieve and maintain these, continuous medical education, including being versed with the Liverpool Heart and Chest Hospital VTE Policy, is key.

If a DVT or PE is confirmed it should be treated appropriately and reported as an incident as per the incident reporting policy. This allows the Trust to investigate all incidences of DVT/PE that occur.

# LHCH VENOUS THROMBOEMBOLISM RISK ASSESSMENT AND PROPHYLAXIS ALGORITHM



\*Contraindications to mechanical prophylaxis: massive leg oedema, pulmonary oedema, severe peripheral arterial disease, severe peripheral neuropathy, major leg deformity, dermatitis or any other superficial skin condition.

## Introduction to Health and Safety

In practice, the day to day management of health and safety is delegated to the local managers of wards, units and departments. They, in turn, ensure that appropriate assessments and procedures are in place to protect staff, patients and visitors. In addition, everyone, as individual employees, has the duty to report any health and safety concerns to their Manager or Risk Department so the issue can be assessed and action taken. The Health and Safety Advisor provides health and safety advice to all employees, and assists managers with undertaking risk assessments. Managers should also undertake routine monitoring and inspection of Trust premises under their responsibility to check the effectiveness of safety control systems.

### Some Reminders for you

- Do not use mobile telephones in clinical areas that have a high density of medical devices such as ITU/POCCU – they can interfere with medical devices
- Do not use mobile telephones (or any other device) to take photographs
- Report any concerns to your manager
- Do not use faulty or broken equipment
- Ensure that you are trained to use any equipment that you use
- Be aware that patients and visitors can do things that we don't expect
- Dispose of needles safely – 33% of needlestick incidences occur during disposal or because of poor disposal of sharps.
- Don't overfill sharps bins.
- Ensure that you are aware of the contents of a risk assessment for the activities that you undertake.
- Don't take chances or short cuts that can get a job done more quickly or because you 'got away with it last time'.
- You are responsible for keeping your immediate work environment safe and clutter-free.
- If you believe that your work or workplace is affecting your health, tell your manager.
- Report any incidents or near misses promptly using the Trust Incident Reporting system.
- Don't copy the bad habits of your work colleagues.
- If you are not sure of anything see your manager.
- You can be disciplined or end up in Court if you don't follow procedures and something happens or someone is harmed.

No one comes to work to be injured or see anybody else injured. The cost of an incident can vary considerably and it is important that any costs are minimised so that maximum resources can be channelled into patient care.

Health and Safety law lays down specific duties for employers and employees. This is identified in legislation such as the Health and Safety at

Work, etc Act, 1974 and various Regulations such as the Management of Health and Safety at Work Regulations and the Control of Substances Hazardous to Health (COSHH) Regulations. There are many other pieces of legislation that deal with topics such as asbestos, pregnancy, latex, personal protective equipment, lone working, manual handling and display screen equipment, to name but a few.

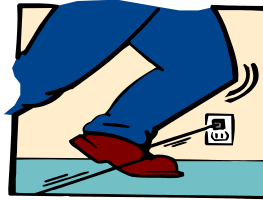
The Trust has policies or guidance on many of these and they are available on the Trust website or from managers.

As individuals, we all have a responsibility to look after ourselves, our work colleagues, patients and visitors.

### Key Work place hazards and risks areas in Healthcare

#### 1. Slips, Trips and Falls – some examples to note: -

- Risks in clinical areas, particularly for vulnerable patients – e.g. water by wash areas, body fluids on the floor, talc and plastic bags on the floor
- Patients have died in other hospitals because of falls
- Uneven floor surfaces
- Trip hazard of trailing wires, particularly in office areas.



#### 2. Dangerous Substances – some examples: -

- Latex – patients and staff can be sensitive to latex gloves or products containing latex
- Chemicals – e.g. formalin / formaldehyde and sterilising agents
- Blood-borne viruses such as HIV and hepatitis – these can be present in blood and body fluids
- Be particularly careful with needles
- Cytotoxic drugs – these can be present in patient's body fluid.
- If you are clearing up a spillage of body fluid, a chemical spill or unknown fluid wear gloves that have been deemed suitable for the task.

Personal protective equipment (e.g. gloves, masks, safety goggles, visors, safety shoes) should be used when necessary and should be identified in the risk assessment

The COSHH (Control of Substances Hazardous to Health) Regulations help the Trust to safely deal with many dangerous substances.

Many substances in sufficient quantity can be hazardous to health. The purpose of the COSHH Regulations is to ensure exposure to products that are known to be hazardous to health is eliminated, or if this is not possible, for exposure to be limited to acceptable for recognised hazardous substances.

'Hazardous' refers to a substances potential to cause harm. Hazardous substances can take many forms, including:-

<b>Biological agents</b>	For example, bacteria, viruses, (may be present on used needles and in body fluids or laboratory samples)
<b>Substances used directly for Work Activities</b>	For example, cleaning solutions, chemicals, oils, cytotoxic drugs
<b>Substances generated by work activities</b>	For example, welding fumes, dust from sanding or cutting wood/metal
<b>Substances that occur naturally</b>	For example, in gardening activities, bird and vermin droppings

Exposure to hazardous substances can occur through the following methods:

<b>Inhalation</b>	Breathing in dust, vapours, fumes, airborne particles, etc
<b>Indigestion</b>	Eating or swallowing hazardous substances or via contamination through contact with unwashed hands
<b>Absorption</b>	Absorbed through the skin or mucus membranes of the body nose eyes
<b>Injection/inoculation</b>	Through sharps injuries, scratches or via open wounds

The effects of hazardous substances on the human body can range from minor irritations through to fatal respiratory diseases or cancers, and the effects of hazardous substances can be anything from immediate through to months or even years after the actual exposure.

Suppliers of substances with hazardous properties are required to label their products with black on orange pictogram. As a general rule of thumb, if a substance has a warning pictogram, COSHH applies. The most common types of pictogram are shown below:-

**Explosive**  
**Oxidising Agent**  
**Harmful/ Irritant**  
**Extremely/ highly flammable**  
**Highly toxic/toxic**  
**Corrosive**

Substances that display these pictograms could be used for cleaning, laundry, and other domestic duties. However, this list is not exhaustive and it is the responsibility of Managers to ensure all products and substances are checked

for a pictogram. If there are in any such substances in use, a COSHH assessment must be undertaken. Further details on what is involved in undertaking a COSHH risk assessment can be obtained from Risk Management.

Suppliers also have to provide recipients of hazardous substances with a document, known as a Safety Data Sheet (SDS). The Safety Data Sheet gives the recipient the information necessary to take measures relating to health and safety at work and the protection of the environment and contains information about how the product should be stored and used, and how to deal with the product in the event of a spillage or contact with eyes, skin, etc. SDSs should be available from manufacturers or suppliers for all the products with an orange pictogram in use in your area.

COSHH risk assessments should be written and seen by users before any handling of substances occurs. Please note that risk assessments should take account of pregnant workers or any other vulnerable workgroup.

### **3. Musculo-skeletal Injuries – remember: -**

- Follow your manual handling training; remember TILE – Task, Individual, Load, and Environment.
- These can affect parts of the body other than the back (e.g. arm, wrist)
- Use manual handling aids; don't take shortcuts
- Nurses are 2 to 3 times more likely to suffer musculo-skeletal injuries
- Repetitive activities such as using a screwdriver or excessive mouse use at a computer can cause such conditions as repetitive strain injury (RSI) – ensure that you take a break from the work every hour or better still try and replace the activity with a safer method (e.g. use an electric screwdriver)
- Advice can be obtained from the Trust Manual Handling Advisor

### **4. Stress**

Stress is defined by the Health and Safety Executive (HSE) as 'the adverse reaction people have to excessive pressure or other types of demand placed on them'.



In the workplace, indications that employees may be suffering from high levels of stress may include:

- High staff turnover.
- Increased long term sickness.
- Reduced staff morale.

- More complaints
- Reduced productivity or performance.
- Poor time keeping.

It is an employer's responsibility to assess the risk of potentially stressful aspects of employees work and to put into place control measures accordingly. It has been established through case law in recent years that an employer is entitled to assume his employees are able to cope with the demands of the job unless the employee specifically tells them otherwise. At that point the employer is obliged to see what can reasonably be done to assist the employee to cope with the stressful elements of their job.

Some stress in our life can be a good thing; it keeps us challenged, alert and active. It is when the level of stress starts to get too much, especially for a prolonged period, that it becomes a problem. Each individual reacts differently to pressures placed upon them. Equally, an individual's reaction to being in a stressful situation will differ from another's. The following are recognised signs and symptoms of people suffering from stress: -

#### **Physical**

Headaches  
Neck Pain  
Indigestion  
Palpitations  
Insomnia  
Nausea

#### **Psychological**

Anxiety  
Worry  
Depression  
Panic Attacks  
Negativity

#### **Behavioural**

Agitation  
Anger  
Indecision  
Mistakes  
Shouting  
Being quieter than usual

Most people will suffer from one or more of these symptoms at some point in their life without the cause necessarily being stress related. Repeated or excessive episodes may be an indication of stress, but there may be other causes, so it is recommended that medical opinion is sought. Coping strategies also vary from person to person. Common strategies include exercise, hobbies, talking with friends or family, balanced diet and yoga. The services of the Occupational Health Department are available to any member of staff if they have concerns about stress or other health issues.

Further guidance is available from Human Resources and the Trust's policy on stress.

### **5. Violence and Aggression**

Violence and aggression towards healthcare staff has been a concern for many years and the Trust is determined to protect its staff against assaults or abuse that is either verbal or physical.

## How to maintain own and others Health and Safety

### Responsibilities of the Trust

The responsibilities of the Trust, usually through its managers and lead by the Chief Executive, includes the following: -

- To provide a safe and healthy workplace for patients, visitors and staff
- To provide safe equipment (e.g. electrical testing)
- To provide safe work areas and environment – this is why health and safety inspections are undertaken twice a year.
- Provides information, instruction and training to all employees
- Undertake risk assessments
- Provide safe systems of work
- Production of health and safety-related policies.
- Supporting a system where issues can be treated openly and fairly in relation to health and safety

### Responsibilities of the Employee

These include: -

- Attend any training sessions they are required to.
- Follow any instructions, procedures, policies or training they have been given
- Provide safe standards of clinical practice through compliance with the regulations of any professional bodies
- Participate in the risk assessment process if required
- Ensure that they report any problems with equipment or in the workplace
- Ensure that they do not tamper with equipment so that their own safety or that of others is put at risk.
- Report any incidents using the Trust reporting system – this should be done promptly because the Trust has a legal duty to report certain incidents to the Health and Safety Executive (HSE) within 10 days.
- Report any ill-health that they have if they believe it is related to work.
- If you are a witness to an incident and are required to write a statement, please ensure that it is clear, concise, avoids personal feelings and deals with just the facts.

## Understanding and Promoting Safe Working Practice

### What are Good Practices?

The following are good practice when present in an organisation: -

- Promoting a positive health and safety culture
- Good communication so that people are made aware of risks

- Regular health and safety inspections
- Regular health and safety audits that look at management systems in place
- Creation of Safe Systems of Work – that is, procedures for safe people, with safe equipment in a safe place.
- Ensuring that Safe Systems of Work are followed.
- Having an incident reporting system in place and learning from any incidents.
- Having a blame-free culture so that incidents, risks and concerns are reported promptly.

## Safety in the Home

Health and Safety should be considered in the home environment. Think about how safe your home is and the measures you can take to make it safer.

- Commonest accident in the home is a fall/fall from height (55%)
- Gardening injuries at the weekend may mean days off work in the week – think before you lift that paving slab!
- Injuries to children – burns, scalds, falls
- Injuries to elderly relatives – more than 1500 over 75's die from fall related injuries every year

### **ACTIVITY: RISK MANAGEMENT/HEALTH & SAFETY**

Do not forget to complete the on-line assessment on [My PACT](#)



Please note:

- If you achieve 80% or more you have been successful
- If you do not achieve 80% you will not be deemed as compliant with your essential mandatory training and will need to repeat the test.